

Arizona State Veteran Home - Phoenix
4141 N. Third Street
Phoenix, Arizona 85012

Functional Assessment

Applicant's Name: _____ Date: _____

Date of Birth: _____ Current Living Arrangements: _____

Person completing This Form: _____ Relationship to Applicant _____

Applicant's Medical Diagnoses: _____

For each area of functioning listed below, please describe to the best of your ability the amount and type of assistance the applicant requires.

BATHING

Does applicant take a shower, tub bath or sponge bath? _____

How often does he/she bathe? _____

How much assistance is needed? _____

DRESSING

How much assistance does applicant receive in dressing (including selecting and getting clothes from closet, putting on undergarments and using fasteners)? _____

Additional Comments _____

TOILETING

Does applicant require assistance with toileting (including getting to and from bathroom, cleaning self after elimination and arranging clothes)? _____

If yes, how much assistance is needed? _____

Does applicant have a catheter? What type? _____

Does he/she have a colostomy? _____

Is applicant able to control urination? _____ Bowel movements? _____

If no, how often do "accidents" occur? _____

MOBILITY

Does applicant walk (list assistive devices used, i.e., walker, cane) or does he/she use a wheelchair? _____

Does he/she need assistance getting out of bed or a chair? _____

If yes, how much assistance is needed? _____

EATING

Does applicant feed self or require assistance eating? _____

Does he/she use adaptive equipment while eating (i.e., plate guard, special spoon, etc.)? _____

Is he/she on a special diet? _____

How would you describe applicant's appetite? _____

Height _____ Weight _____

MEDICATION

List applicant's current medications:_____

Any known drug allergies?_____

Is applicant using oxygen (if yes, how much and how often)?_____

PROSTHESES

Does applicant have an arm or leg prosthesis?_____

Does he/she wear dentures (upper and lower)?_____

Does he/she use a hearing aide?_____

SKIN

Does applicant presently have bed sores (if yes, where and for how long)?_____

Does he/she have skin rashes?_____

Does he/she experience swelling of the legs or feet?_____

ORIENTATION

Is applicant alert and oriented or does he/she exhibit confusion? (If confused, is it ongoing, often, or occasional?)_____

For individuals who are confused and disoriented:

Does the applicant attempt to wander? _____

If yes, how often? _____

Is he or she willing to return if given direction? _____

OTHER HEALTH CONSIDERATIONS

Does applicant currently use physical or chemical restraints? If yes, describe type and frequency: _____

Has he/she ever been hospitalized for mental health problems? If yes, state when, where, and why: _____

Does applicant maintain active and satisfying relationships with family and friends? _____

Does he/she have a history of drug or alcohol abuse? If yes, please describe: _____

Is applicant currently receiving physical, occupational, speech, or respiratory therapy? If yes, list type of therapy, reason for, and frequency received: _____

Additional Comments: _____
